Plumbers Local Union No. 1
Welfare Fund

Out of Network Claim Form

HEARING

CPSHEARING

CPS USE ONLY
V #:

PATIENT INFO

INSURED NAME (Last Name, First Name)				PATIENT NAME (Last Name, First Name)	5 DIGIT CE EMPLOYEE ID (or Insured's SSN)
ADDRESS	CITY	STATE	ZIP	PATIENT DATE OF BIRTH	RELATIONSHIP TO MEMBER ☐ Self ☐ Spouse ☐ Dependent

I acknowledge receiving the services specified below. I authorize release of any information related to this claim to the Plan and/or Claims Administrator of this Vision Care Plan. Any allowable or covered benefits will be reimbursed to the insured.

PATIENT'S SIGNATURE: _____ DATE: _____

PROVIDER INFO

DATE OF SERVICE	PROVIDER'S NAME	COMPANY / STORE NAME	
ADDRESS	CITY	STATE ZIP	TELEPHONE NO. ( )

EVALUATION & DEVICE

EVALUATION $_____

Make and Modem of Hearing Aid Dispensed _____

☐ Right Ear _____ ☐ Left Ear _____

Cost of Hearing Aid: $_____

Total Paid By Member: $_____

DO NOT MARK IN THIS BOX

EXAM $_____

DEVICE $_____

TOTAL AMT PAID $_____

THIS FORM MUST BE COMPLETED AND RETURNED WITH A PAID ITEMIZED RECEIPT.

MAIL CLAIM TO:

CPS HEARING
11 HANOVER SQUARE, 8TH FLOOR
NEW YORK, NY 10005
(212) 675-5745

11/2016